SullivanCurtisMonroe
INSURANCE SERVICES, LLC

2027 Annual Physical Exam Certification

Date Submitted: _____Employee Name: _____

To Be Completed by Health Care Provider:

Dear Health Care Provider:

Your patient, _____ is participating in an employer-sponsored health improvement program. One component of this program is completing an annual physical examination. The date of service for this physical examination must be between November 1, 2026, and October 31, 2027, in order to receive rewards under the program.

This is to certify that on the date indicated below, I, a licensed medical physician / a licensed physician assistant / or a licensed advanced nurse practitioner/ provided an annual physical examination for the individual indicated above.

_____
Date of Examination

_____ _____
Health Care Provider Signature Print Name of Health Care Provider

I also certify that as a licensed medical physician / a licensed physician assistant / or a licensed advanced nurse practitioner that the above individual is tobacco free:

Yes, Tobacco Free _____ No, not Tobacco Fee_____

Name, Address, Telephone # of Health Care Provider:

Please Note: All medical information is CONFIDENTIAL and disclosure will only be made consistent with the Health Insurance Portability and Accountability Act of 1996 and state privacy laws.

To Be Completed by Employee:

Employee/Patient: I am providing the above certification to SCM voluntarily and by signing below, I authorize SCM to use the above information to confirm that I have met the criteria necessary to qualify for the Healthy Rewards Program. I fully understand that providing this information and participation in the Healthy Rewards Program offered by SCM is voluntary, and that I freely provide the above certification from my health care provider.

_____ _____
Employee/Patient Signature Date

Submit Form to Bryan Kilduff, Human Resources Manager at SCM
Confidential Fax: 949 878-4912
Email: bkilduff@sullicurt.com